MEDDIC-MS Data Book

Medicaid Encounter Data Driven Improvement Core Measure Set

Vol. 1--2004 HMO Aggregate Performance Data Wisconsin Family Medicaid and BadgerCare

Wisconsin Department of Health and Family Services
Division of Health Care Financing, Bureau of Managed Health Care Programs

November 2005

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Volume 1: 2004 HMO Aggregate Performance Data
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Results on Non-clinical Performance Measures included in the CAHPS® Medicaid/BadgerCare Enrollee Satisfaction Survey are reported separately in the "CAHPS® Medicaid/BadgerCare Enrollee Satisfaction Survey Executive Summary Report." View the most recent report at: http://www.dhfs.state.wi.us/medicaid7/providers/index.htm

MEDDIC-MS Data Book, Vol. 1, 2004 HMO Aggregate Performance Data, Wisconsin Family Medicaid and BadgerCare, State of Wisconsin, Department of Health and Family Services, October 2005.

Introduction and Background

MEDDIC-MS (Medicaid Encounter Data Driven Improvement Core Measure Set) is Wisconsin's set of standardized performance measures for Family Medicaid and BadgerCare (the State Children's Health Insurance Program, SCHIP) managed care. Use of MEDDIC-MS was approved by the Centers for Medicare and Medicaid Services (CMS) as part of its review of the state's quality improvement strategy in August 2003.

In October 2003, the Agency for Healthcare Research and Quality (AHRQ) recognized MEDDIC-MS for inclusion in the National Quality Measures Clearinghouse (NQMC®). To view the measure summaries on the NQMC, go to: http://www.qualitymeasures.ahrq.gov/resources/measureindex.aspx and scroll down to "State of Wisconsin."

MEDDIC-MS is an automated system, utilizing HMO encounter data and other State-controlled electronic data sources, without paper medical record review. This improves patient privacy protection, reduces costs and improves measure accuracy. Medical record review is used for data validity audits, ambulatory quality of care audits, when HMOs wish to augment their encounter data and for special audit functions.

The Department of Health and Family Services' (DHFS) data services vendor extracts data and calculates each HMO's performance on the measures. This improves data consistency and accuracy over having each HMO calculate and report its own rates.

MEDDIC-MS includes *Targeted Performance Improvement Measure* (TPIM) topics that have been in use in Wisconsin for a number of years. An integrated goal-setting system applies to some of these measures. It also includes *monitoring measures* that are used for utilization trending and as clinical outcome measures.

Performance reports for prior years are available on the Wisconsin Medicaid Managed Care Website. To view these reports, please go to: http://www.dhfs.state.wi.us/medicaid7/providers/index.htm and scroll down to "Provider Quality Reports."

The data in this booklet presents program-wide performance rates for all HMOs combined on all MEDDIC-MS performance measures based on CY 2004 data, as well as trend data based on past performance.

Complete technical specifications for the MEDDIC-MS measures are available upon request. Contact: Gary R. Ilminen, RN at (608) 261-7839 or ILMINGR@DHFS.STATE.WI.US.

New Enrollee Health Needs Assessment (NEHNA) survey

In 2001, the DHFS implemented a proactive approach to performance improvement called the New Enrollee Health Needs Assessment (NEHNA) survey. The NEHNA survey is administered by the state's enrollment broker at the time of enrollment. Enrollee-specific health care needs, including special health care needs such as those for chronic conditions, are identified in a voluntary telephone survey. Information about those needs is shared with the enrollee's HMO. In this way, the Department facilitates quality improvement by informing HMOs of the health care needs of new enrollees, even before the enrollee may have a visit with their doctor.

Care Analysis Projects

In 2001, the DHFS implemented an innovative approach to care management called Care Analysis Projects (CAP). Through CAP, enrollee-specific health care needs are identified from encounter data and those needs are shared with the enrollee's HMO. CAP allows the Department to assist HMO outreach to individuals with unmet needs.

CAP focuses on several chronic conditions and on the provision of key preventive services. Chronic conditions included are congestive heart failure, asthma, and diabetes. Preventive health services include lead screening and prenatal risk assessment.

MEDDIC-MS and CAP work together. CAP provides data-driven targeted intervention and MEDDIC-MS provides performance assessment.

HMO Performance Improvement Projects

Since the early 1990's the HMO contract has required HMOs to complete at least two performance improvement project reports annually. These projects drive quality improvement.

To view a summary of HMO Performance Improvement Project topics, go to:
HTTP://WWW.DHFS.STATE.WI.US/MEDICAID7/REPORTS_DATA/MCORGPERIMP.HTM

Other volumes in the MEDDIC-MS 2004 Data Book include:

MEDDIC-MS 2004 Data Book, Volume 2, HMO-specific Performance Data, Wisconsin Family Medicaid and BadgerCare.

Results on Clinical Performance Measures

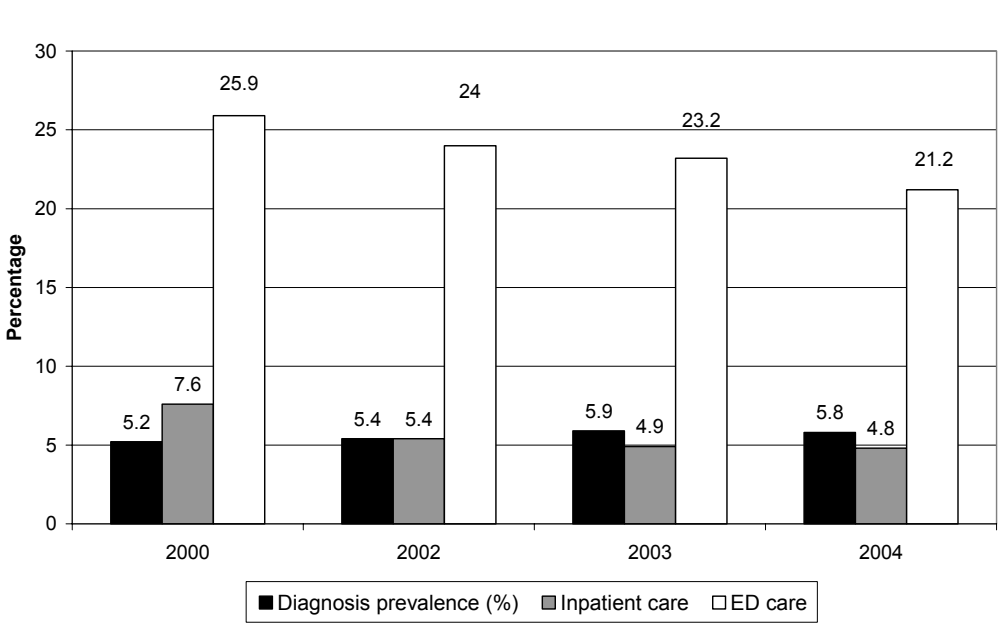
Asthma care

Monitoring measure

Asthma is a chronic disease of the lungs. Asthma causes episodes where airflow in and out of the lungs is reduced by constriction of the airways and by excess mucous. Asthma affects between 12 and 15 million Americans, including nearly 5 million children. The disease can have fatal complications.

Asthma can be managed with appropriate medications and patient education. Early diagnosis, patient/parent education and appropriate treatment are crucial to effective management and maintenance of good quality of life.

Prevalence--the percentage of enrollees with the diagnosis of asthma—has increased slightly since 2000.

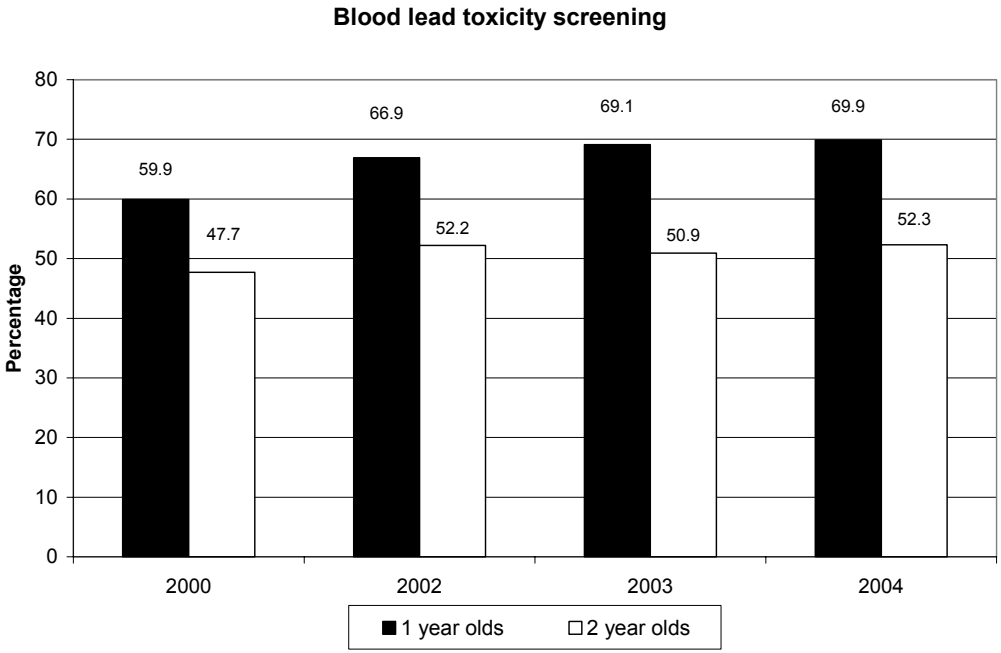


HMOs have shown steady progress in ambulatory care for this condition, with the utilization of both emergency department care and inpatient care declining between 2000 and 2004. Use of ED care for asthma decreased from 25.9 percent in 2000 to 21.2 percent in 2004; use of inpatient care for asthma declined from 7.6 percent in 2000 to 4.8 percent in 2004.

HMO disease management programs for asthma may have been an important factor in the improvement; 9 of 13 Medicaid/BadgerCare HMOs offer asthma disease management. In addition, 8 of 13 HMOs have conducted performance improvement projects on asthma care since 2000. Finally, the Department has operated a Care Analysis Project on asthma since 2001 and it is an item on the New Enrollee Health Needs Assessment (NEHNA) survey.

Blood lead toxicity screening

Targeted performance improvement measure



Children in Medicaid are at risk for exposure to lead in their living environment. Screening for blood lead toxicity is required for children at age one and two years and up to age six if elevated blood lead levels or risk factors are present.

Blood lead toxicity screening rates have slowly improved between 2000 and 2004 for both one and two year old children.

The screening rate for one-year-old children increased from 59.9 percent in 2000 to 69.9 percent in 2004. The screening rate for two-year-old children increased from 47.7 percent to 52.3 percent in the same period.

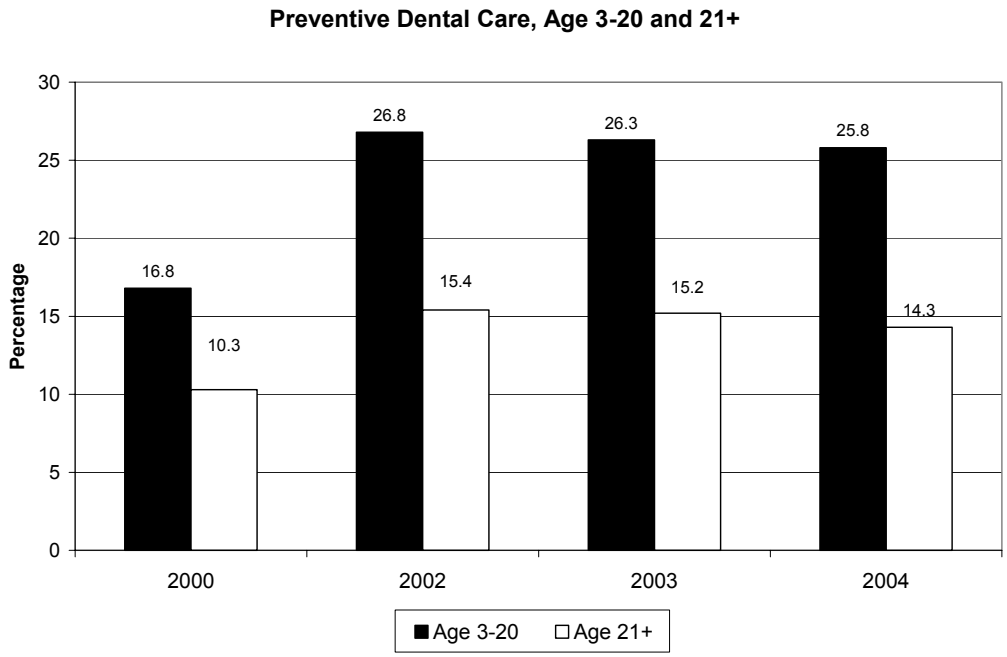
In 2001, the Department implemented a Care Analysis Project (CAP) on blood lead toxicity screening. Recipient-specific lead testing data is shared with the individual's HMO in an effort to assist HMOs with identification of children in need of lead screening. This facilitates outreach and follow-up for children who have not received screening. This on-going effort may be a factor in the improvement in the lead screening rate trends.

Since 2000, 5 of 13 Medicaid/BadgerCare HMOs have conducted performance improvement projects on lead screening, four of those were conducted since 2002.

In 2004, the DHFS implemented performance improvement goal-setting for this measure.

Dental (preventive) services

Targeted performance improvement measure



Preventive dental services include initial and comprehensive dental examinations, prophylaxis, topical application of fluoride and application of sealants.

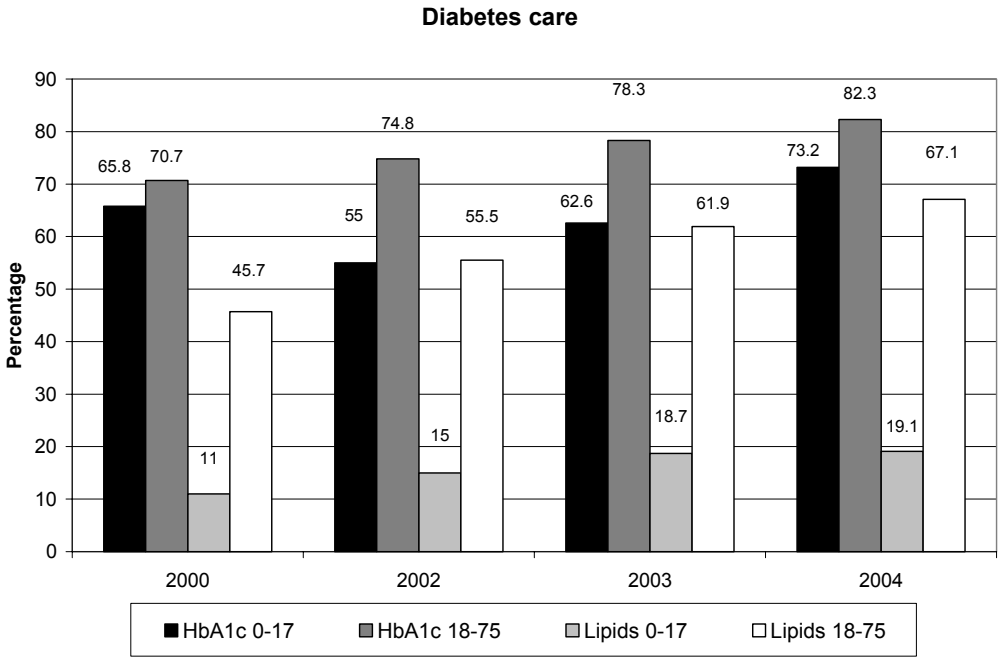
Dental care can prevent development of dental caries, tooth loss, oral infections, abscesses and other problems. Preventive dental services are of particular value soon after the eruption of teeth for in young children. Teeth generally first erupt between age 6 and 28 months and emerge enough to benefit from preventive care between 1 and 3 years.

Three HMOs in the Milwaukee area of 13 participating in Medicaid/BadgerCare offer dental services. HMO enrollees in the rest of the state receive dental benefits on a fee-for-service basis; but about half of all HMO enrollees receive dental benefits through their HMO.

Despite apparent initial improvement in access indicated by higher utilization for both age groups, the overall percentage of enrollees receiving preventive dental services remains relatively low, and has decreased somewhat each year since 2002. Improving delivery of dental care remains a performance improvement opportunity.

Diabetes care

Targeted performance improvement measure



Diabetes mellitus is a chronic condition that can affect the heart, kidneys and eyes. But, with proper care, serious problems can be reduced or prevented.

Two blood tests are important for effective diabetes care.

One is the hemoglobin A1c (HbA1c), a blood test that indicates the level of blood sugar control over time.

The other test is the lipid profile, a blood test that monitors the levels of "fats" (lipids) in the blood stream.

These tests allow assessment of key indicators for diabetic management. The chart reflects the percentage of HMO enrollees diagnosed with diabetes who received the tests. The percentages are reported for two age groups: birth (0) to age 17 years and 18 to 75 years of age.

Care for diabetes has steadily improved between 2000 and 2004. Lipid test rates for 18-75 year olds increased from 45.7 percent in 2000 to 67.1 percent in 2004. HbA1c test rates for 18-75 year olds increased from 70.7 percent in 2000 to 82.3 percent in 2004.

The HbA1c rate for 0-17 years of age increased from 65.8 percent in 2000 to 73.2 percent in 2004. The rate for lipid testing for 0-17 years of age has also improved, increasing from 11 percent in 2000 to 19.1 percent in 2004.

Seven HMOs have conducted performance improvement projects on diabetes care since 2000 and 11 of 13 HMOs have disease management programs for diabetes. It is an item on the New Enrollee Health Needs Assessment (NEHNA) survey and it has been a Care Analysis Project topic since 2001. In 2004, the DHFS implemented performance improvement goal-setting for this measure.

EPSDT (HealthCheck) comprehensive well-child exams

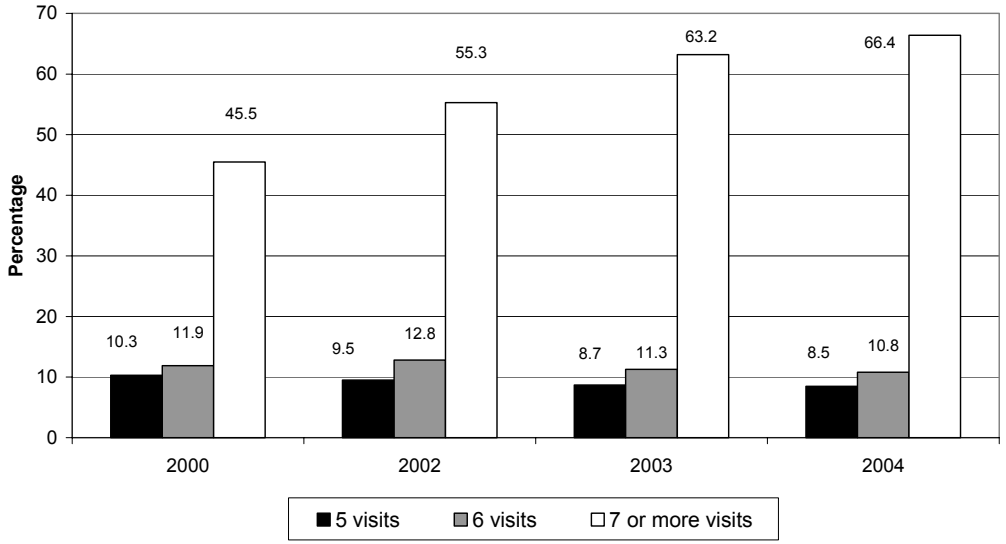
Early, Periodic Screening, Diagnosis and Treatment (EPSDT) services are federally required for children in Medicaid. Wisconsin calls EPSDT services HealthCheck screens. HealthChecks include an unclothed physical exam, age appropriate immunizations, lab work, including blood lead toxicity tests, health and developmental history, vision and hearing assessment and oral assessment beginning at age 3. Nine HealthCheck visits should be provided to each child by age two years.

Sustained improvement has occurred in the percentage of children receiving 7 or more HealthCheck exams by age two years. The rate has increased from 45.5 percent in 2000 to 66.4 percent in 2004.

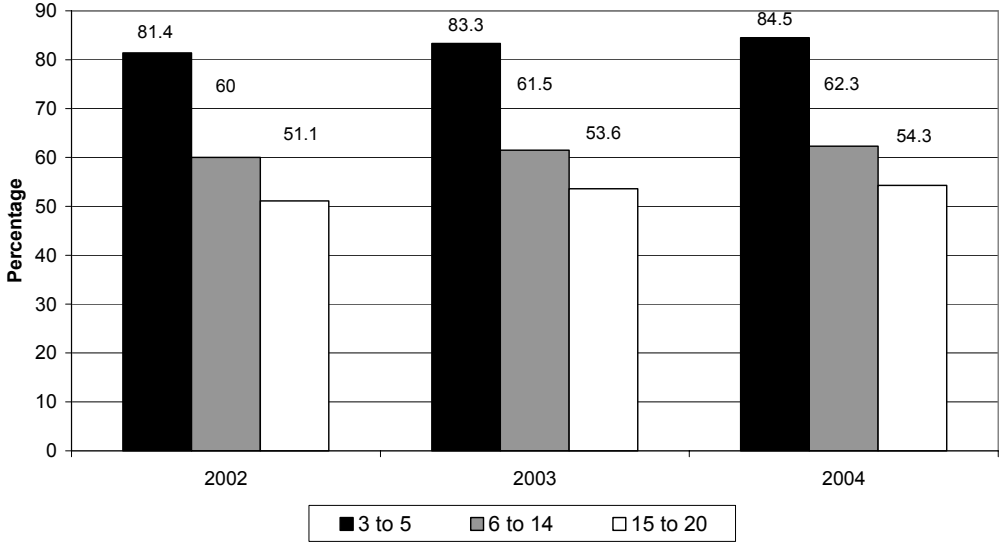
The rates for children in each age cohort between age 3 and 20 years of age receiving at least 1 visit in the look-back period have also shown sustained improvement since 2002.

Ten of thirteen Medicaid/BadgerCare HMOs have conducted performance improvement projects on HealthCheck since 2000. Data for age group 3-20 years was not calculated in 2000-01.

Early, Periodic Screening, Diagnostic and Treatment (EPSDT) Services· -HealthCheck, Children from Birth to Age 2 Years

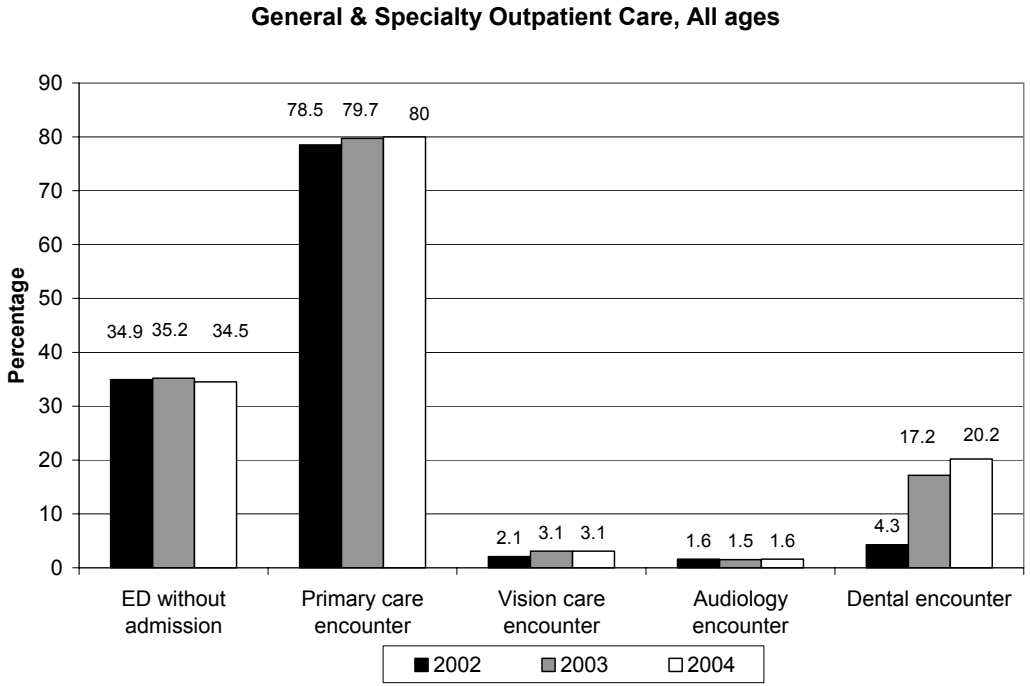


Early, Periodic Screening, Diagnostic and Testing (EPSDT) Exams for Children Age 3-20 years



General and specialty care-outpatient

Monitoring measure



This measure assesses access to emergency care that does not result in subsequent hospitalization, access to primary care, vision care, audiology services and dental care. Access to these outpatient or ambulatory care services is essential for overall health maintenance and improvement.

The measure tracks what percentage of Medicaid and BadgerCare HMO enrollees had access to those services on at least one occasion during the look-back period.

About one-third of all HMO enrollees had at least one emergency department (ED) care encounter that did not result in subsequent hospitalization in 2004. This was consistent with 2002 and 2003. High ED use may be caused by a number of factors, and may be an indication of problems with access to primary care. The DHFS has initiated a collaborative project with a variety of stakeholders to address ED use.

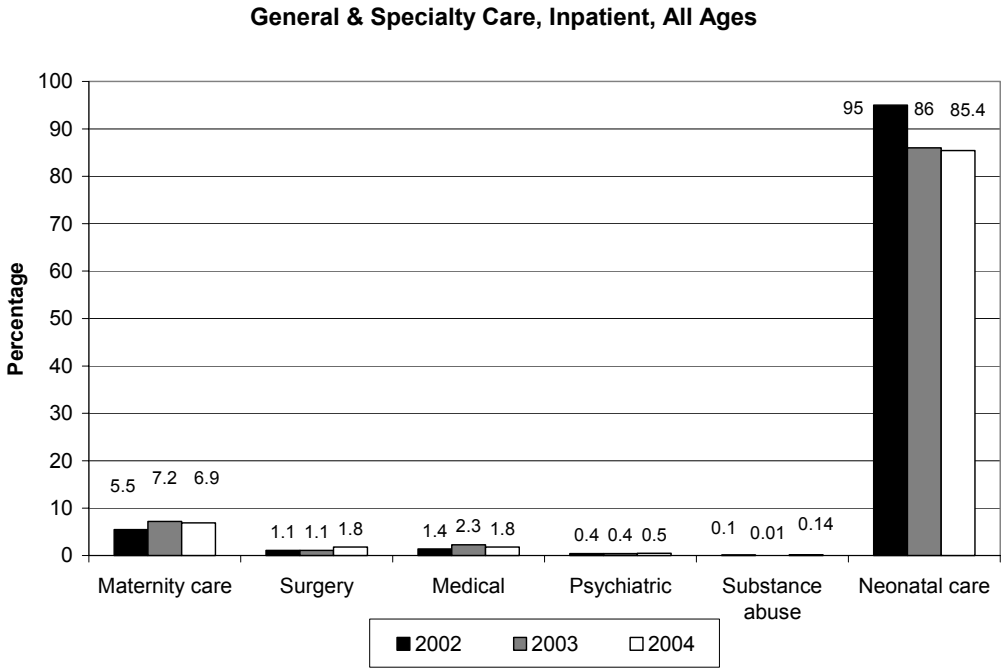
Primary care access for enrollees of all ages was good, with 8 out of every 10 HMO enrollees having at least one primary care encounter in the look-back period for in 2004, a slight increase over both 2003 and 2002. Access to vision and hearing services remained stable.

Only 3 participating HMOs provide dental care under their contract with the Department. Access to and utilization of general dental services improved significantly from 2002 to 2004, increasing from 4.3 percent to 20.2 percent. General dental services generally include interventions such as fillings. See also "Dental (preventive) care" on page 10 for further information on other dental care services.

The need for vision, audiology and other special outpatient care services are an item on the New Enrollee Health Needs Assessment (NEHNA) survey.

General and specialty care-inpatient

Monitoring measure



Some conditions may require care or services that cannot be provided on an ambulatory or outpatient basis. Those conditions may require hospitalization, referred to as inpatient care.

Inpatient care may be necessary for a variety conditions, requiring several types of inpatient care. General categories of care monitored include maternity, surgery, medical, psychiatric, substance abuse and neonatal (newborn) care.

This monitoring measure is useful as a tool in assessing access and utilization of inpatient care services. By itself, this measure is not an all-inclusive indicator of sufficiency of access to services, or of appropriateness of care. However, when used in conjunction with other data such as satisfaction, grievance and appeal data, outpatient care data and other measures, it provides a reasonable basis for assessment of overall service delivery.

Maternity, surgical, medical, psychiatric and substance abuse care rates have remained about the same from 2002 to 2004. Neonatal care has declined somewhat between 2002 and 2003, but remained above 85 percent in 2003 and 2004.

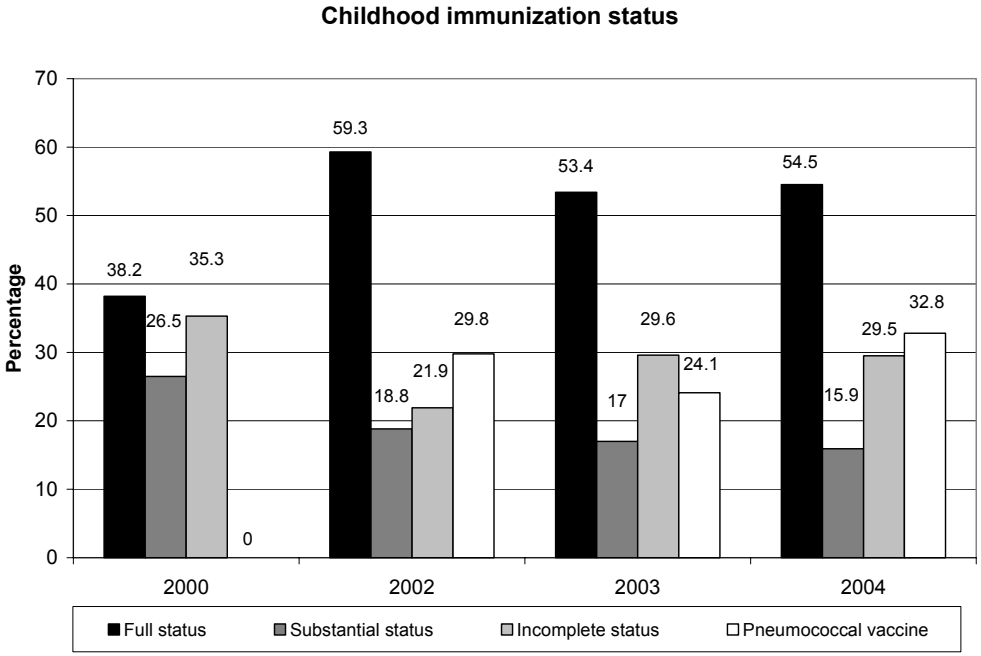
Information about enrollee inpatient care needs is an item on the New Enrollee Health Needs Assessment (NEHNA) survey.

Immunizations for children

Targeted performance improvement measure

Immunizations can protect young children from potentially serious infectious diseases. Immunization is believed to be one of the safest and most effective health care services available.

This measure assesses the percentage of children enrolled in Medicaid/BadgerCare HMOs who have achieved full immunization status, substantial immunization status and who have incomplete immunization status. The rate of administration of 4 doses of the multivalent pneumococcal vaccine is included as a monitoring measure. Substantial status refers to children who have received most but not all of the doses of certain vaccines given in multi-dose series believed necessary to confer substantial immunity.



The rate of full immunization status increased 1.1 percent from 2003 to 2004, and the overall trend in full immunization has increased 16.3 percent since 2000. The rate for children receiving 4 doses of pneumococcal vaccine increased 8.7 percent from 2003 to 32.8 percent in 2004.

Vaccine shortages affecting several antigens occurred in 2002 and 2003. Those antigen shortages contributed to a decline in the vaccination rate in 2003 from the 2002 rate. Vaccine shortages also affected the rate of pneumococcal vaccination in that time period.

Only two HMOs have made childhood immunizations the subject of performance improvement projects reported to the DHFS since 2002.

In 2004, the DHFS implemented performance improvement goal-setting for this measure.

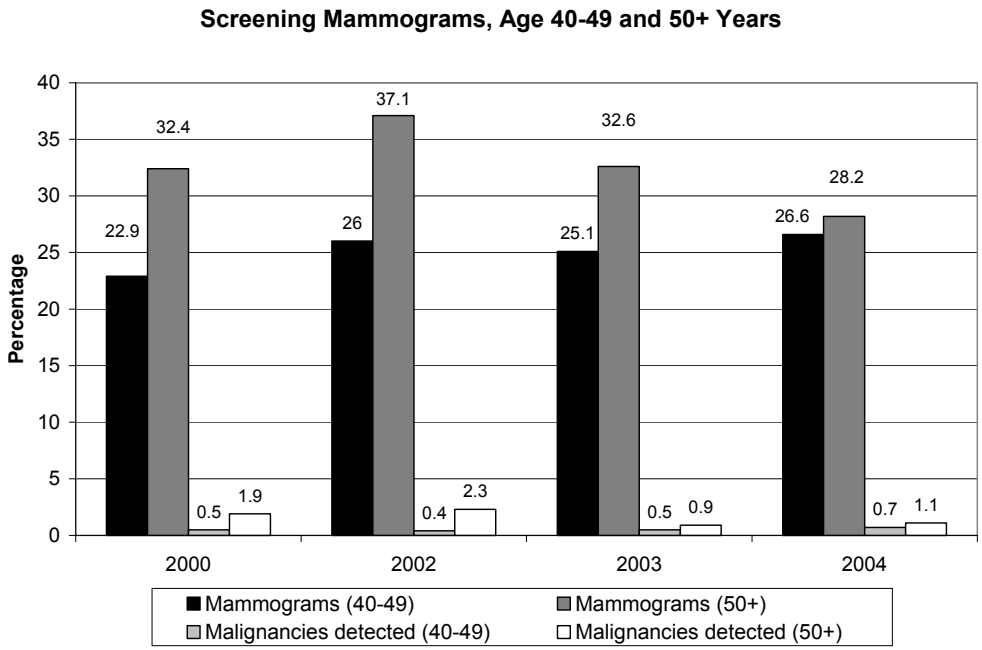
Mammography (screening) and malignancy detection

Monitoring measure

Screening mammography is recognized as a highly effective method for early detection of breast cancer. Early detection of breast cancer improves outcomes of treatment and long-term survival.

The American Cancer Society and the National Cancer Institute each recommend that women over age 40 have regular screening mammograms.

Only a small percentage of enrollees in Medicaid/BadgerCare are women over age 40. Nevertheless, provision of screening mammography is important because of the benefits of early detection and treatment.



This measure assesses screening mammography rates for women aged 40-49 and over age 50 years. The percentage of women screened in the 40-49 age group has increased somewhat since 2000, from 22.9 percent to 26.6 percent. However, the rate for women over age 50 has decreased somewhat since 2000, from 32.4 percent to 28.2 percent.

The outcome measure for this service, detection of breast malignancies, has ranged from 0.4 percent to 0.7 percent in the 40-49 year age group since 2000. The malignancy detection rate in the 50+ age group has ranged from a high of 2.3 percent in 2002 to a low of 0.9 percent in 2003.

In 2004, 16,014 women qualified for inclusion in this measure; that is, they *should have* received a screening mammogram. Given the 4-year average detection rate of 1.5 percent for women over 50 and 0.5 percent for women 40-49, that means 84 additional women may have been diagnosed early if all the women who *should have* been screened were screened. The cost of providing screening mammograms is included in the HMO capitation rate as a preventive health service, so the Department should consider options to work with HMOs to improve delivery of this service.

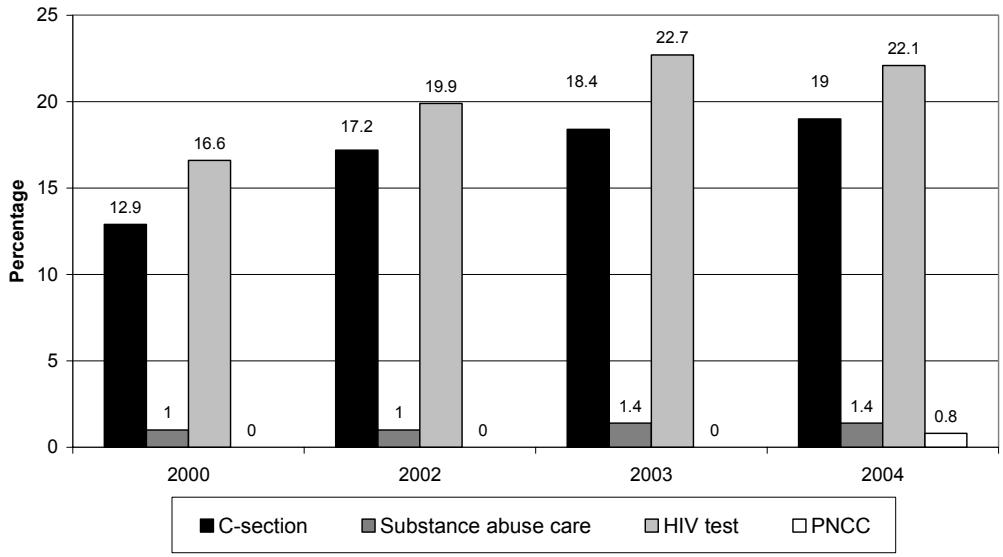
Maternity care

Monitoring measure

Cesarean section (C-section) childbirth may be the safest form of delivery in certain circumstances. However, C-section deliveries should be used only when necessary. Due to the number of women of child-bearing age in Medicaid/BadgerCare, monitoring the use of the procedure is important.

Other health care services often provided in the perinatal period are important to the health of both mother and child. Three such services are provision of substance abuse treatment services, voluntary HIV screening tests and prenatal care coordination (PNCC).

Maternity Care, C-sections, Perinatal Substance Abuse Care, Voluntary HIV Testing & PNCC



The rate of births by C-section has steadily increased from 12.9 percent in 2000 to 19 percent in 2004. There has also been a national trend toward increased use of C-sections. According recent data from the Centers for Disease Control and Prevention, the national rate has increased from 20.8 percent in 1995 to 25.3 percent of all births in 2001.[1]

Provision of substance abuse care in the perinatal period remained stable at about 1.0 percent, increasing only slightly to 1.4 percent in 2003 and 2004. Provision of HIV screening increased from 16.6 percent in 2000 to over 22 percent in 2003 and 2004.

PNCC was not calculated in 2000 and 2002. The rate was zero in 2003 and 0.8 in 2004.

Information about pregnancy is included in the New Enrollee Health Needs Assessment (NEHNA) survey.

[1] Kozak LJ, Owings MF, Hall MJ. National Hospital Discharge Survey: 2001 annual summary with detailed diagnosis and procedure data. National Center for Health Statistics. Vital Health Stat 13(156). 2004.

Mental health/substance abuse (MH/SA) follow-up care within 7 and 30 days of inpatient discharge

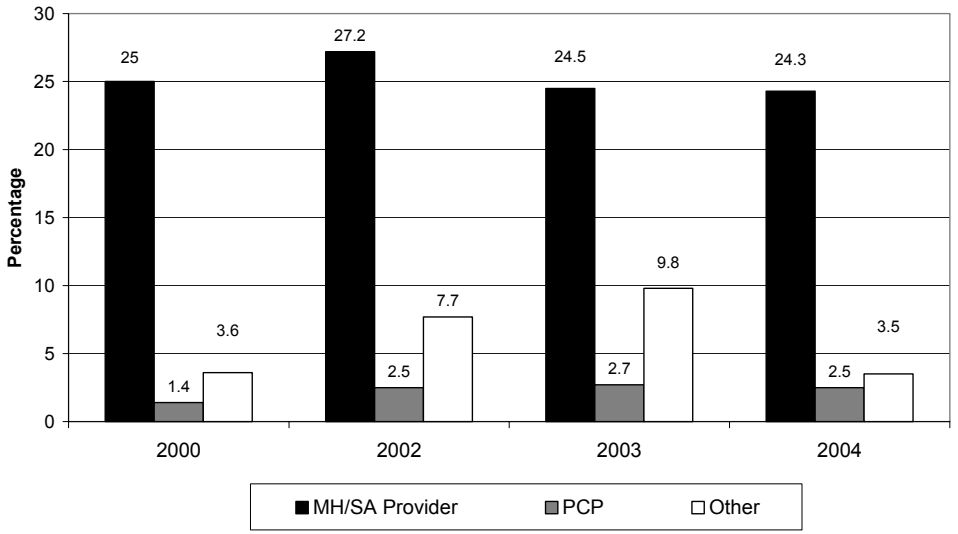
Targeted Performance Improvement Measure

Research has shown that follow-up care on an outpatient basis for individuals who have had inpatient care for mental illness or substance abuse is effective in reducing readmission to the inpatient setting for the same diagnosis.[2]

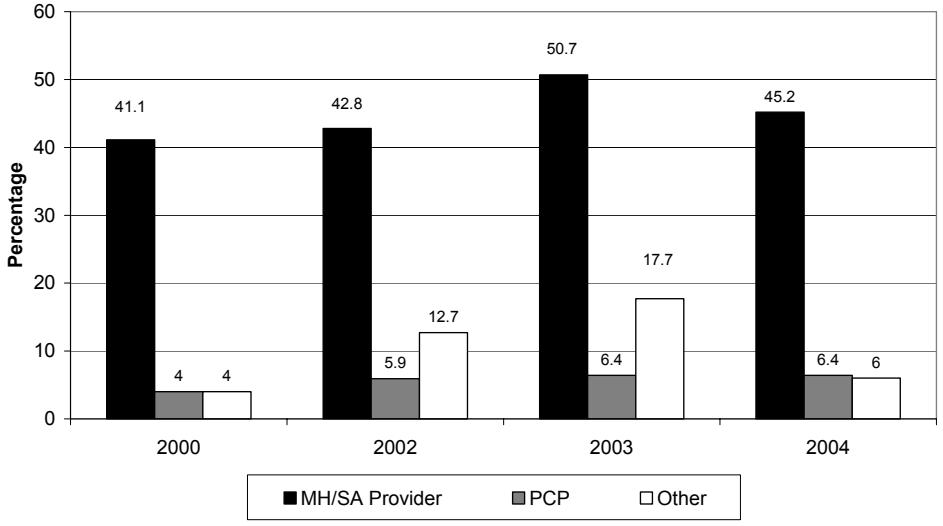
This measure evaluates provision of outpatient follow-up care by both specialty care providers and primary care providers (PCP) within 7 days of discharge and within 30 days of discharge from an inpatient mental health or substance abuse stay. For instances when appropriate service codes appear on encounter records but the provider type is not specified, the services are included in the category "other" to avoid underreporting.

Overall, access to follow-up care, as indicated by utilization data, by all providers had generally increased from 2000 to 2003, but declined in 2004. Follow-up care by specialists within 7 days of discharge has stayed about the same from 2000 to 2004. Follow-up care at 7 and 30 days by PCPs has increased slightly in the period.

Mental Health/Substance Abuse ambulatory care within 7 days of inpatient stay, by provider type, age 6 years and up, all HMOs



Mental Health/Substance Abuse ambulatory care within 30 days of inpatient stay by provider type, age 6+ years, all HMOs



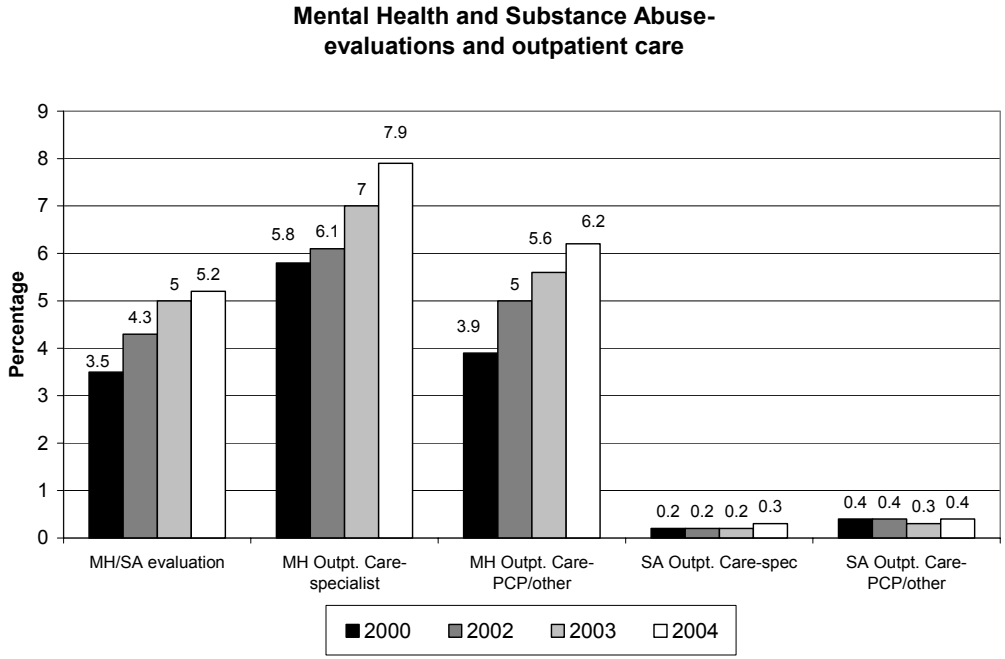
[2] *Evaluation and the Health Professions, Special Edition, State Medicaid Quality Programs*, "Outpatient Utilization Patterns and Quality Outcomes after First Acute Episode of Mental Health Hospitalization," Delmarva Foundation, December 2000.

Mental health/substance abuse-evaluations and outpatient care

Monitoring Measure

The first step in access to mental health and substance abuse (MH/SA) services is often an evaluation by practitioner who specializes in those areas. Monitoring the rate of evaluation and treatment services is useful to detect access trends.

Mental health and substance abuse conditions can often be successfully treated on a day treatment or outpatient basis. Outpatient treatment is often preferred by enrollees rather than inpatient care. Thus, access to day and outpatient treatment services is both preferred by enrollees and useful to reduce the need for inpatient care.



This measure tracks the provision of these services by provider type in order to gain insight into HMO network adequacy. Care by a specialist may be preferable or essential in some instances, however, primary care providers may also be able to provide services in some cases.

Trend data indicates that access to mental health and substance abuse evaluations has increased from 3.5 percent in 2000 to 5.2 percent in 2004. Access to outpatient mental health care by both specialist and primary care providers increased in the period. Access to outpatient substance abuse care from specialist and primary care providers remained unchanged from 2000 to 2004.

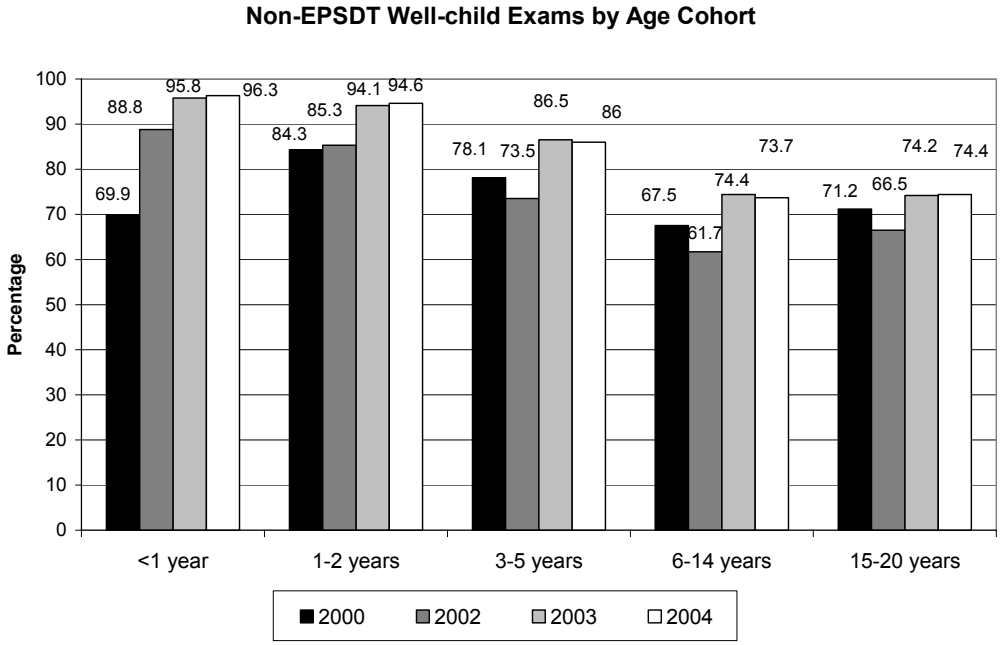
Non-EPSDT well-child exams

Monitoring measure

Non-EPSDT (non-HealthCheck) well-child visits are primary care visits that may be too limited in scope to qualify as EPSDT or HealthCheck visits, but do result in delivery of preventive or other health services.

The positive health and economic effects of well-child services, particularly in early childhood have been demonstrated in a recent study.[3]

The study found that states with the highest rates of provision of well-child visits had the lowest rates of preventable hospitalizations for those children. Conversely, states with the lowest rates of well-child care had the highest rates of preventable hospitalizations.



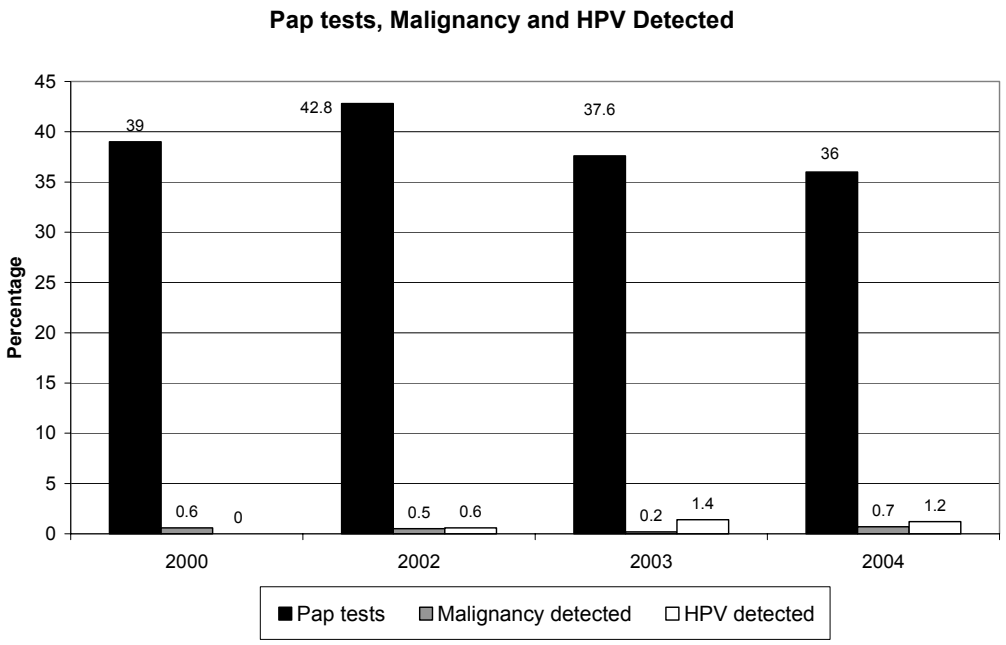
The authors of the study concluded that the "association between preventive care and a reduction in avoidable hospitalizations was robust and was consistent across the states and racial and ethnic groups."

Data for children with at least one visit in the look-back period shows significantly improved access among children <1 year of age since 2000. That rate increased by 26.4 percent. Visit rates in all other age groups have also increased since 2000, though not as significantly as in the one-year-old and under cohort.

[3] *Effectiveness of compliance with pediatric preventive care guidelines among Medicaid beneficiaries*. Hakim RB, Bye BV. July 2001. PEDIATRICS, Vol. 108, No.1:90-97.

Pap tests-cervical cancer screening

Monitoring measure



According to the Centers for Disease Control (CDC), cervical cancer remains a leading preventable cause of death among women. Women of child-bearing age make up a significant number of Medicaid/BadgerCare HMO enrollees. Consequently, providing early detection tests is an important service.

Early detection is relatively easy and is the key to a high probability of survival. The most common method for early detection is called the "Pap test."

The Pap test is generally performed every three years, beginning when the woman becomes sexually active or by age 18 years. Thus, the Pap test is not required annually, and the measure is designed to take this into account.

According to the CDC, Human Papillomavirus (HPV) infection is a causal factor in more than 90 percent of cervical cancers. This measure assesses the detection rates for malignancy and HPV infection.

Provision of Pap tests has decreased slightly from 39 percent to 36 percent for women age 18-65 years between 2000 and 2004. Outcome measure results, the rate of detection of malignancy, for this service have remained about the same. The HPV detection rate has increased slightly from zero percent in 2000 to 1.2 percent in 2004. One HMO has conducted a performance improvement project on increasing Pap test rates since 2000.

Analysis of performance trends, quality improvement opportunities and strategic implications

Calendar year 2004 clinical performance data showed sustained improvement in HMO program performance. Performance data trended from 2000 to 2004 shows that, on a variety of measures, the quality improvement strategy to "ramp up" performance over time appears to be effective.

Summary of trends on selected measures from 2000 to 2004:

- ***Asthma care:*** Prevalence of asthma remained essentially unchanged, but the need for emergency department services for asthma declined from 25.9 to 21.2 percent and the need for inpatient care declined from 7.6 to 4.8 percent.
- ***Blood lead toxicity screening:*** rates improved--increasing from 59.9 to 69.9 percent for 1 year olds and from 47.7 percent to 52.3 percent for 2 year olds.
- ***Childhood immunizations:*** rate for children with full immunization status[4] increased from 38.2 to 54.5 percent.
- ***Dental preventive care:*** rates improved for children age 3 to 20 years from 16.8 percent to 25.8 percent and improved from 10.3 to 14.3 percent.
- ***Diabetes care:*** hemoglobin A1c (HbA1c) testing rate improved from 70.7 to 82.3 percent and lipid profile testing rate improved from 45.7 to 67.1 percent for adult diabetics.
- ***EPSDT (HealthCheck) well-child exams:*** rate for children age 2 years and younger receiving 7 or more exams improved from 45.5 to 66.4 percent. Rates for older children receiving at least one exam increased in each age cohort, though only by an average of approximately 3 percent.
- ***General & specialty outpatient care:*** The rate for ED encounters without subsequent admission increased in 2003 but then dropped in 2004 to nearly the same rate as in 2002—just over 34 percent. Primary care encounter rates edged up to 80 percent. Vision and audiology utilization rates remained about the same. General dental care increased from 4.3 to 20.2 percent.
- ***General & specialty inpatient care:*** Rates for inpatient services generally remained about the same.
- ***Mammography (breast cancer detection for women):*** rate increased from 22.9 to 26.6 percent for women age 40-49. For women 50+ years of age, the rate decreased from 32.4 to 28.2 percent. Malignancy detection remained stable during the period in each age cohort.

[4] Based on Centers for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP) recommendations.

- ***Maternity care:*** C-section rate increased from 12.9 to 19.0 percent. Substance abuse treatment in the perinatal period remained stable at about 1 percent. Voluntary HIV testing rate increased from 16.6 to just over 22 percent.
- ***MH/SA follow-up care:*** Follow-up care within 7 days by specialist remained about the same from 2000 to 2004, about 25 percent; within 30 days it increased from 41 to 45.2 percent, but decreased from 50.7 percent in 2003. Follow-up by PCPs trended up slightly. Follow-up by "other" or "unspecified" providers increased in the 7 day indicator from 3.6 to 9.8 percent and in the 30 day indicator from 4 to 17.7 percent between 2000 and 2003, but decreased in both the 7 and 30 day time frame in 2004.
- ***MH/SA evaluations and outpatient care:*** Evaluations increased from 3.5 to 5.2 percent. Behavioral day treatment by specialists increased from 5.8 to 7.9 percent; by PCPs/others from 3.9 to 6.2 percent. Substance abuse outpatient care by all provider types remained stable from 2000 to 2004.
- ***Pap tests (cervical cancer detection for women):*** This rate decreased from 39 to 36 percent, after having improved to 42.8 percent in 2002. Malignancy and HPV detection rates were stable during the period.
- ***Well-child exams--(non-HealthCheck):*** This rate increased for children birth to age 1 year from 69.9 to 96.3 percent. Rates of provision of this service increased in all other age cohorts up to age 21 years as well.

Sustained, gradual improvement is occurring

Sustained, gradual improvement appears to be occurring across a broad front. It is not generally "breakthrough" improvement that happens in large irregular bursts, but rather, steady incremental improvement.

Those clinical areas where multiple efforts by the DHFS and participating Medicaid/BadgerCare HMOs have been brought to bear appear to have the most significant improvements.

Multiple efforts include such things as HMO performance improvement projects, interventions such as disease management by HMOs, data sharing and targeted outreach by the DHFS such as the Care Analysis Projects (CAP), and early care need identification by the DHFS for HMOs such as the NEHNA (New Enrollee Health Needs Assessment) survey.

For example, emergency department and inpatient care utilization for asthma declined from 2000 to 2004, even though disease prevalence was unchanged (see page 8). The DHFS has operated a Care Analysis Project (CAP) on asthma and provided care need information through the NEHNA survey since 2001. Also, 9 of 13 HMOs have a disease management program for asthma and 8 of 13 HMOs have conducted performance improvement projects on the subject since 2000.

Improvements in diabetes management services occurred between 2000 and 2004 (see page 11). As with asthma, diabetes has been included in the Care Analysis Project and NEHNA survey since 2001. It has been the subject of seven HMOs' performance improvement projects since 2000. In addition, 11 of 13 HMOs have disease management programs for diabetes.

These multiple efforts have contributed to better identification, outreach and ambulatory care for individuals with asthma and diabetes. Multiple approaches appear to be an effective strategy in improving quality of care.

Data suggest performance improvement opportunities may exist in several areas, for example, dental services, provision of Pap tests and screening mammography.

Strategic options

These findings suggest several strategy options for further quality performance improvement program-wide. They include:

- Broaden the Care Analysis Project to include additional topics.
- Increase new enrollee participation in the NEHNA survey.
- Increase the number of topics included in the performance improvement goal-setting system.
- Consider quality improvement performance incentives for HMOs on topics that present performance improvement opportunities.
- Consider options to increase the number and effectiveness of HMO performance improvement projects.

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